City of Boulder New Employee | Benefits Enrollment Form

Please return completed/signed form to HR

Eff. Date: _____

Eff. Pay Period: _____

Employee ID#: _____

EMPLOYEE INFORMATION

Printed Name (First, Middle Initial, Last)_____

Street Address_____ City, State Zip _____

Date of Hire: _____/_____/_____ (MM/DD/YYYY)

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Civil Union ☐ Divorced ☐ Widowed *(provide relationship documentation to enroll dependents)*

Gender: ☐ M ☐ F Date of Birth: _____/_____/_____ (MM/DD/YYYY)

SS#: _____ - _____ - _____ (### - ## - ####) (required by insurance carriers)

Home Phone: _____ Mobile Phone: _____

ENROLLMENT SELECTION

	CIGNA HEALTHCARE	DELTA DENTAL	VISION SERVICE PLAN
Plan:	☐ $500 Deductible Open Access Plan ☐ $1,000 Deductible Open Access Plan ☐ $1,500 Deductible Open Access-HSA Eligible ☐ Waive Medical Coverage	☐ Delta Premier ☐ Delta Preferred ☐ Waive Dental Coverage	☐ Enroll-Base ☐ Enroll-Buy Up ☐ Waive Vision Coverage
Tier:	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family

Add the following Dependents to my coverage:

Dependent's Name (First, MI, Last)	Relationship	Dependent's Social Security #	Gender	Date of Birth (MM/DD/YYYY)	Disabled? (Y/N)	Add to Medical (Y/N)	Add to Dental (Y/N)	Add to Vision (Y/N)

Note: Allowable relationships include spouse, domestic partner, civil union partner, birth child, adopted child, child for whom you have legal guardianship, disabled child over the age of 26, partner's child for whom you are responsible, step child, any other person you have been granted legal guardianship for through the courts.

Health Care Flexible Spending Account (HC FSA)

Available to all benefits eligible employees. Eligible expenses must be incurred between January 1 and March 15 of the following year. Any monies remaining in the account as of March 31 are forfeited.

☐ Enroll ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction for the remainder of the year?*	Annual Election Amount *(minimum $120, maximum $2,550)* *$*_____

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Health Savings Account (HSA)

Available to all employees who elect the $1,500 Deductible plan. Eligible expenses must be incurred after the creation of the account. Any monies remaining in the account at the end of the year are retained by the employee. Employees age 55 or older may contribute an additional $1,000.

☐ Enroll ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction each pay period?*	Per Pay Period Election Amount *$*_____

Dependent Care Flexible Spending Account (DC FSA)

Available to all benefits eligible employees. Eligible expenses must be incurred between January 1 and December 31. Any monies remaining in the account as of March 31 are forfeited.

☐ Enroll ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction for the remainder of the year?*	Annual Election Amount *(minimum $120, maximum $5,000)* *$*_____

Life and Accidental Death & Dismemberment Coverage

Basic Life and AD&D provided by the city*: Management/Non-Union = 1.5x salary BMEA = $50,000 IAFF = $25,000; City pays 1/3 of the premium BPOA = $100,000; Paid for through VEBA ☐ Enroll ☐ Waive (only applies to IAFF) *Review the plan certificate for details on coverage amounts at various ages and for benefits for dismemberment.	Additional Life purchased through payroll deduction: $120,000 guaranteed issue for the employee $20,000 guaranteed issue for the spouse Amounts over the guaranteed issue require a supplemental form for medical underwriting approval. You may elect spouse coverage up to 100% of the amount requested for the employee. Election Amount for Coverage on Employee *(minimum $10,000, maximum $300,000)* *$*_____ Election Amount for Coverage on Spouse *(minimum $10,000, maximum $300,000)* *$*_____	Additional Life purchased through payroll deduction: You may elect up to $10,000 on your children. The entire amount is guaranteed issue. The cost is the same, no matter the number of children you have. Election Amount for Coverage on Child(ren) *(You may elect $2,500, $5,000, $7,500, or $10,000)* *$*_____

Beneficiary Designation: The employee is automatically the beneficiary on Spouse and Child coverage amounts. Below please designate your primary and contingent beneficiaries.

<u>Primary</u>		
Name:	Relationship:	% of benefit:
Name:	Relationship:	% of benefit:
<u>Contingent</u> (Only if all primary beneficiaries pre-decease you)		
Name:	Relationship:	% of benefit:
Name:	Relationship:	% of benefit:

Note: A beneficiary can be a person, an estate, a trust or an organization.

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Short and Long Term Disability Coverage	
Short Term Disability is provided to all Mgmt/Non Union employees with less than 3 years of service or less than 5 years of service for BMEA employees. The coverage is 60% of the employee's gross weekly earnings up to $1,500. Benefits are available after the exhaustion of all accrued but unused sick time or the 8th day of illness or injury. Long Term Disability provided by the city for all Mgmt/Non Union with less than 3 years of service or less than 5 years of service for BMEA employees: The coverage is 50% of the employee's salary. IAFF and BPOA members over the age of 55 years old are covered under the city paid plan. Otherwise they are covered by FPPA for disability. ☐ Enroll ☐ Waive	
Legal Ease Plan	
☐ Enroll, requires a supplemental form ☐ Waive	
Supplemental Retirement Savings	
457 plan administered by ICMA	401(k) plan administered by PERA
☐ Enroll, requires a supplemental form ☐ Waive	☐ Enroll, requires a supplemental form ☐ Waive

Signature for Insurance Carriers

☐ I certify that I have been given the opportunity to enroll for group insurance benefits as offered by and through the City of Boulder. I understand that I cannot change my elections until the next annual enrollment period unless I have a qualifying life event. I also certify that by completing this enrollment, I agree to abide by the eligibility, enrollment and election procedures for my City of Boulder benefits.

☐ I acknowledge that participating providers are not agents or employees of the city and provider participation may change.

☐ I agree to utilize the appeal procedure(s) established by the carrier(s) for resolving claims disputes. Depending on the conditions set forth by the carrier, this agreement may require binding arbitration instead of a court trial for dispute resolution.

☐ I acknowledge that carriers may release certain information about me and/or my dependent(s) when required under federal or state law, or pursuant to legal process, and may release and obtain medical information to or from other carriers, providers, and public agencies for the purpose of providing health care services, to facilitate payment for these services, and to conduct related administrative operations.

☐ I hereby apply for the above listed coverage for myself and eligible family dependents listed in this enrollment. I understand that if I/we are accepted for coverage, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

☐ I hereby authorize the City of Boulder to deduct the necessary premiums from my paycheck each month.

Date: _____ Signature: _____

Employees working in standard positions but working less than 20 hours per week are not eligible to participate in any of the above insurance plans.